VENABLE® LLP

Two Hopkins Plaza, Suite 1800
Baltimore, Maryland 21201-2978

Telephone 410-244-7400
Facsimile 410-244-7742

www.venable.com

Peter P. Parvis

(410) 244-7644

ppparvis@venable.com

October 26, 2006

VIA HAND DELIVERY

Linda Cole, Chief
Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services

Dear Ms. Cole:

On behalf of Hospice of Baltimore ("HOB"), a subsidiary of GBMC HealthCare and an affiliate of Greater Baltimore Medical Center, we provide the following comments to the Maryland Health Care Commission's (the "Commission") draft update (the "Draft Update") to COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Service (the "SHP"). By this letter, and for the reasons detailed below, HOB respectfully requests that the Commission reconsider the Draft Update's proposed changes in section .13(C). We also understand that Hospice Network of Maryland, Inc. is simultaneously submitting separate comments to the Commission, which HOB adopts and incorporates herein by reference.

General Overview of HOB

Since 1994, HOB has helped thousands of patients in Baltimore City, Baltimore County, Carroll County, Harford County, and Howard County make their final journey in peace, comfort and dignity. As the largest not-for-profit hospice organization in Maryland, HOB provides quality, compassionate physical, emotional and spiritual end-of-life care and services to individuals diagnosed with a life-limiting illness. HOB's interdisciplinary team of specially trained staff and volunteers are committed to providing comfort oriented care with a holistic approach aimed at achieving comfort throughout the progression of the illness. Members of the hospice team work closely together to provide services including medical care, nursing care, social work, home health and volunteer assistance, as well as spiritual and grief counseling and support. HOB provides care wherever a patient and family are most comfortable: at home, in a nursing home or retirement community, or at its inpatient facility, Gilchrist Center for Hospice Care.

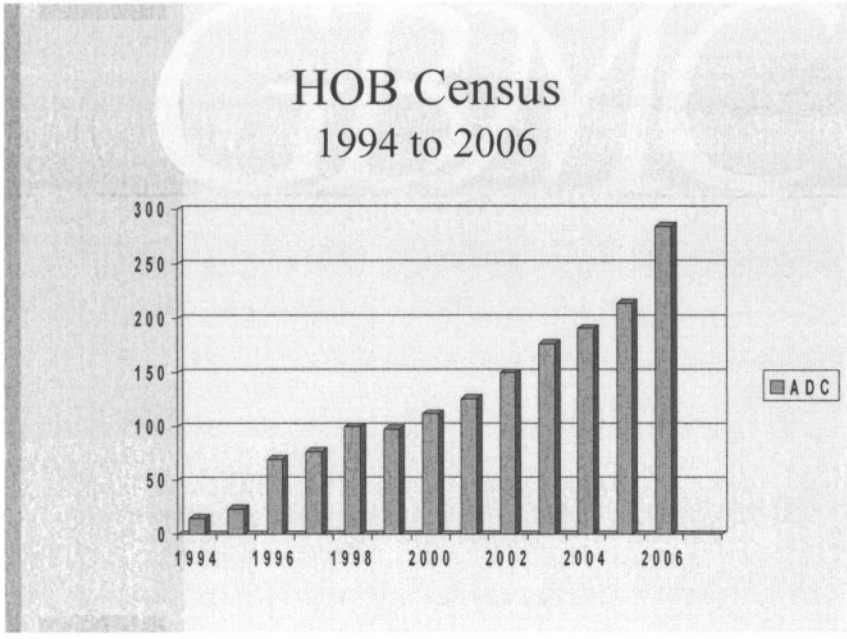
Unlike nursing homes or continuing care retirement communities ("CCRC"), HOB and other certified hospice providers in the State provide a greater level of care than CCRCs are likely to provide. CCRCs provide at best a residential facility for the remainder of a patient's life, whereas hospices such as HOB provide care for the patient and their family beyond the life of the patient. At HOB, families may receive bereavement counseling for up to 13 months following a patient's death. Moreover, hospices such as HOB provide a different standard of care than CCRCs. HOB is certified by Medicare, accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), and is a member of the National Hospice and Palliative Care Organization ("NHPCO"), the Hospice Alliance of the National Capital Area and the Hospice Network of Maryland. As a NHPCO member, HOB must provide and comply with heightened quality of care standards. Similarly, for a hospice to be a Medicare provider, a hospice must meet Conditions of Participation[1] to become licensed and certified by state regulators and to be allowed by the Centers of Medicare and Medicaid Services to continue to participate in the Medicare hospice program. Without certification of their compliance with these standards, hospices cannot receive reimbursement from Medicare or Medicaid for patients enrolled in their program. Providing CCRCs the same legal status as hospices such as HOB, while not requiring them to provide the same care or meeting the same standards of care, would diminish the integrity of area hospices and the value of the comprehensive and holistic care they provide.

Since 2004, HOB's average daily census has increased by over 100 patients.

---

[1] The Conditions of Participation generally cover:

- General Provisions and Administration: These subregulations outline the structure of the hospice and the general administration of the program including quality assurance, ability to pay, use of volunteers, and maintenance of clinical records, care, continuation of care irrespective of ability to pay, inservice training, quality assurance, interdisciplinary groups, volunteers, licensure requirements, and maintenance of clinical records.
- Core Services: These sub-regulations cover the provision of core services that must be routinely provided directly by hospice employees. These core services are nursing, physician, medical social work and counseling services, including bereavement. A hospice may use contracted staff, if necessary but must maintain the professional, financial, and administrative responsibility for the services.
- Other Services: These sub-regulations cover the nature of other services that may be provided – therapies (physical, occupational and speech-language pathology), lab tests, medical supplies, home health aide or homemaker and short-term inpatient care.



Use of 2004 needs projections to determine if HOB is fulfilling the needs of hospice patients in each county it provides services today does not accurately reflect HOB's capacity.

Section .13(C) of the Draft Update Preferentially Treats CCRCs Differently Than All Other Health Care Facilities, Which the SHP Was Designed to Prevent

Section .13(C) of the Draft Update, if approved, would grant CCRCs operating a specialized home health agency permission to provide hospice care to CCRC residents based on only limited criteria. This special treatment of CCRCs violates the principles of the Certificate of Need ("CON") process and its statutory mandates, and makes the need calculation in Section .15 of the Draft Update virtually meaningless. Through its statutory authority and responsibilities, the Commission is responsible for the SHP's development and administration, whereas the SHP provides the policies, review standards, and need projections against which applications for CON are evaluated. See Health General Article, §§ 19-118 through 19-139. The SHP is a policy and procedural guidebook that controls Commission decisions on the establishment and activities of health care providers and services defined by law as

"health care facilities"[2] requiring CON review and approval as determined by Maryland's legislature.

Since the enactment of the statute creating the former Maryland Health Resources Planning Commission ("HRPC") in 1982, hospice care programs have been included in the definition of "health care facility" for purposes of CON review requirements. However, since most home health agencies and virtually all hospice programs existing at that time had been created by hospitals or nursing homes as a facility-based medical service, statutory language was added over the next several years to clarify that any geographic expansion (beyond their current jurisdictions) by an existing hospice required an additional CON. Existing programs of both kinds were "grandfathered" as these successive additions to Commission and licensing law established additional requirements. In 1987, the State legislature imposed a separate State licensure requirement for hospice programs, which explicitly provided that, except for a program with a limited license, a person seeking licensure "shall have a certificate of need . . . for the hospice program to be operated." Health General Article, §19-906(c)(1).

The importance of the background of Maryland's CON law rests in the equity the law aimed to accomplish among health care facilities. Before 1987, nothing explicitly prevented existing hospices from creating new branch offices to simply expand into additional regions of the State or to sell them to create new hospices without CON review and approval. The first SHP, issued in 1983, noted the inequity of this practice, since anyone else proposing a new hospice was required to obtain a CON. Hospitals and nursing homes were permitted to set up hospices under their existing licenses, provided that they did not exceed new-service revenue thresholds then in effect. In 1987, the legislature added provisions that explicitly required CON approval to establish a new hospice; to expand an existing hospice beyond its present approved jurisdictions; and to transfer the ownership of a hospice. The legislature recognized the inequity in the previous system and required that applications to establish or expand hospice were subject to CON review, including the requirement to demonstrate compliance with all of the requirements of the SHP.

[2] The statute defines "health care facilities" for purposes of CON review at §19-114(e), and delineates the actions by proposed or existing health care facilities that require CON review and approval at §19-123.

The focus on equity – the level playing field – is a central reason why the CON law provides for no uniform or blanket exemption from the CON review process. The legislature expressly states in statutes those limited circumstances where a CON is not required. See Health General Article, § 19-120. In an application for CON approval, all proposed new hospices must demonstrate consistency with the standards for CON review in the Long Term Care Services section of the SHP (COMAR 10.24.08.06), and address the general review criteria in the CON procedural regulations (COMAR 10.24.08.01). The Draft Update's section .13(C) provides a completely new mechanism and unique and disparate treatment of CCRCs as compared to other health care facilities in the CON review process, without any statutory basis for the preferential treatment.

Section .13(C) appears to permit CCRCs, as compared to any other health care facility, to obtain a CON to provide hospice care based on limited and poorly defined criteria instead of the complete list of criteria to which all other facilities desiring to provide hospice care are required to meet:

SHP Requirements for Obtaining a CON for All Health Care Facilities	**Section .13(C) of the Draft Update Proposed Requirements for Obtaining a CON for a CCRC**
• Demonstrate need as well as location in a county where the SHP indicates need for a new hospice	• ?
• Direct Services: lists services that the provider is required to offer directly.	• Demonstrate quantitatively that there exists an unmet need that it intends to address
• Direct or contractual services: lists services that the provider is required to offer either directly or contractually.	• An existing specialty home health agency serving only the resident subscribers of one or more CCRCs must demonstrate that the proposed specialty hospice program:
• An applicant shall provide bereavement services to the family for a period of at least one year after the death of the patient.	o can comply with all other review standards in this subsection and meet applicable Medicare Conditions of Participation for hospice programs;
• An applicant to establish a new hospice program shall have available trained caregiving volunteers, to meet the needs of	o will present a cost-effective alternative to the CCRC's current practice of contracting with or referring clients to

SHP Requirements for Obtaining a CON for All Health Care Facilities	Section .13(C) of the Draft Update Proposed Requirements for Obtaining a CON for a CCRC
patients and families in the hospice program	existing general hospice programs serving the jurisdiction in which the CCRC is located;
• An applicant shall provide appropriate instruction to, and support for, persons who give primary care to patients in those patients' homes.	o will provide each person in the CCRC who is referred for hospice care with a list of all general hospice programs authorized to serve the jurisdiction in which the CCRC is located; and
• Requires an applicant to provide have and provide documentation of policies for charity care, a time limit for determining if an individual is eligible for charity care, and means for informing prospective clients of these policies and procedures.	o will not restrict the ability of a resident subscriber to choose to receive hospice services from any hospice program authorized to serve that jurisdiction.

These criteria are vague and do not provide the clearly understood criteria that should be in the SHP. For instance, the Draft Update does not define or provide any guidance on how a CCRC can demonstrate that "there exists an unmet need that it intends to address". This vagueness is compounded by the fact that the Draft Update does not clearly distinguish between need, volume and capacity, thereby providing less clarity to the CON process that is designed specifically to address unmet needs in the State.

Section .13(C) Undermines the Importance and Validity of the SHP's Needs Analysis

Since the first SHP, the Commission has measured hospice capacity and projected hospice need on a county-specific basis and the Commission's strict review of CON applications in compliance with these measures has determined market entry accordingly. The SHP, in its rules governing the threshold for scheduling CON review in jurisdictions where the SHP projects need for new service capacity, provides that the Commission will not docket an application to provide additional hospice services in a jurisdiction if the maximum net number of additional hospice clients to be served in that jurisdiction is below 250 in the target year. COMAR 10.24.08.05P. Moreover, the

State's need for hospice care programs is projected according to a detailed method in the SHP that describes the assumptions and calculations involved in need projection for all of the long term care services regulated by CONs. See COMAR 10.24.08.07. HOB agrees with the large case number contained in the Draft Update for urban areas (although it strongly disagrees with applying a "rural" application to largely urban and suburban counties such as Carroll and Frederick).

As described above, section .13(C), if approved, would violate this clearly identified needs assessment and would replace it solely in the case of CCRCs with a subjective needs determination that is neither defined by any geographic limitation nor identified by any methodology for calculation. By basing a CCRC's special CON review on a subjective needs assessment, the CON's historically objective and identified needs assessment will be replaced with a vague and unclear statement requirement CCRCs to show that need exists. In the absence of a methodology, and a definition of "unmet need", however, there is no guidance in how that need showing will be judged. The lack of objectivity is a fatal flaw in a system designed to avoid the creation of unnecessary facilities and services.

It is clear that giving CCRCs – whose population is largely if not exclusively over age 65 – the right to operate even limited population hospices without full CON review would make the need methodology virtually meaningless. Suppose, for example, that there is an applicant for a hospice in a county in which CCRCs are located. The applicant would file a letter of intent and the lengthy review process for all CONs would be initiated. The Commission's decision on the applications would be based on all of the evidence in the record applied to all the standards in the SHP and review criteria. Somewhere during this process, one or more CCRC could request review under the Section .13(C) of the Draft Update, if approved. It is entirely unclear how anyone would calculate the impact of the CCRC's submission on the SHP's needs requirements that the traditional applicants must meet. The reason is that it can not be calculated, because Section .13(C) neither addresses nor provides any guidance on how a CCRC's "need" calculation will affect other applicants for a hospice CON in the same geographic area.

What is a docketing rule?

An applicant that is not a CCRC can not file a CON for a hospice in a county that the SHIP does not recognize as eligible for a new program. It appears that a CCRC in such a county avoid this restriction by reason of the "special docketing"

rule. If it can, it remains unclear how it can demonstrate compliance with the SHP that does not recognize any need in the county. This raises the issues discussed below.

Section .13(C) May Violate the Public's Rights to Comment on CON Applications

The CON law was drafted and specifically incorporates important due process protections for the public that go hand in hand with the SHP's objective of not granting a facility the right to establish new line of business without first considering the impact this will have on the public and the need for such a business. See COMAR 10.24.01.08 and 10.24.01.09. Currently, all health care facilities wishing to establish a new business or facility or expand their facilities must file letters of intent, which would be published and start a lengthy process under timelines established by regulation, including pre-application conference, filing, completeness review, docketing, notice of docketing, opportunity for participation by those interested in the review, additional questions, appointment of a Commissioner as a Reviewer, additional questions, a proposed decision, followed by opportunity for the applicant or interested parties (if any) to file written exceptions and to make oral arguments to the full Commission. The timetable extends to 180 days or beyond. The decision is based on all of the evidence in the record applied to all the standards in the SHP and review criteria. This level of participation involves due process and facilitates community wide discussion of important issues.

Section .13(C) of the Draft Update could undermine this process. Section .13(C) is described as a docketing rule "to determine whether an applicant for hospice services meets the necessary criteria to allow initiation of [CON] review by docketing." This, however, is not clear from the Section's own language. If section .13(C) is merely a docketing rule, then a CCRC applying for a CON would still have to comply with all of the requirements embodied in the SHP and the needs analysis every other health care facility applying to be a hospice would need to comply with. If this were the case, and as the SHP currently projects the lack of need for new hospice care programs in most counties, no CCRC in such counties could demonstrate that any needs are presently unmet and no applications would be permissible for docketing or present a project that is approvable. Yet, section .13(C) appears to permit CCRCs to demonstrate different criteria in a CON review than other health care facilities and avoid the SHP's current needs projections. If this were the case, section .13(C) is not simply a docketing rule but is an exemption rule that would exempt CCRCs from the normal CON application and review process. If section .13(C) is an exemption, the

implications on the review process subject to public comment and open review become unacceptable. The ramifications on CON review and due process are neither identified nor addressed in section .13(C) and the Commission should not approve it when its impact on the public's rights to comment on CCRC hospice applications remains unclear.

Conclusion

If CCRCs wish to provide hospice care, they should be subject to the same standards and review as other health care facilities providing the same services. By exempting CCRCs from the normal CON review process and exclusively providing them the right to provide hospice services to residents, the Commission will create a unique and unprecedented preference for CCRCs. The Commission does not have the right to do this. The legislature is solely empowered to change the scope and nature of the CON law and the Commission's authority is limited to enforcing that law. The Commission should not create disparate and preferential treatment for certain health care facilities to the disadvantage of others, which is exactly what the Draft Update will accomplish if approved. The Draft Update appears to afford CCRCs the right to bypass all of the clear and unambiguous requirements for a CON and do exactly what the CON law was designed to prevent: grant health care facilities the right to provide redundant and unnecessary services at great economic and social cost to communities in need. Moreover, there is no evidence of any need for other health care facilities to provide hospice services to the population using a CCRC, as Maryland is already well served by many fine hospices, each of which would be harmed in varying degrees without any improvement in access or meeting an unproven unmet need.

If you have any further questions regarding this matter, please feel free to contact me.

Sincerely,

Peter P. Parvis/mlb

Peter P. Parvis
Venable LLP
Counsel to Hospice of Baltimore

cc: Catherine Boyne (via email)
Jack Tranter, Esq. (via email)
Meredith L. Borden, Esq.

BA3/341838-v1